STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 01 B. WING	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN VILLAGE	2026 E 54TH ST INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/30/12 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, American Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered. The east wing of the second	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a desk review in lieu of an onsite post survey revisit on or after September 29, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	floor of Washington Manor houses an Alzheimer wing. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 151 and had a census of 142 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage. The facility was found in compliance with the state law in regard to smoke detector coverage. All areas where residents have customary access were sprinklered except for the exterior canopy at the Harrison Hall Main Entrance. All areas providing facility services were sprinklered except the detached storage and repair shed. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/05/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as the kitchen was held open only by a device arranged to automatically close the door upon activation of the fire alarm system. This deficient practice could affect 60 residents, kitchen staff and visitors in the Main Dining Room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 12:10 p.m. to 2:55 p.m. on 08/30/12, the east door in the set of two kitchen exit doors to the Main Dining room was held open by a door stop which would not allow the door to close automatically upon activation of the fire alarm system.	K0021	K 021 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified for the alleged deficient practice**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No residents were identified for the alleged deficient practice · Integrated Electronics will install a door holder that will automatically close upon activation of the fire alarm system on September 21, 2012. The Dietary Department was in-serviced on September 17, 2012 that the door will automatically close upon activation of the fire alarm system**What measures will be**	09/29/2012

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	Based on interview at the time of observation, the Director of Maintenance Director acknowledged a door stop was used to hold open the east door in the set of two kitchen exit doors to the Main Dining Room which would not allow the door to automatically close upon activation of the fire alarm system 3.1-19(b)		**put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Department Managers/designee will round daily to ensure a hazard free environment.**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Maintenance stall will conduct rounds. If concerns arise the data collected will be submitted to the CQI committee for review. **Compliance date:** September 29, 2012	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 kitchen doors opening into the Main Dining Room closed automatically or upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch into the door frame when closed to keep the door tightly closed to resist the passage of smoke. This deficient practice could affect 60 residents, staff and visitors in the vicinity of the Main Dining Room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 12:10 p.m. to 2:55 p.m. on 08/30/12, the east door in the set of two kitchen exit doors to the Main Dining room is not equipped with a self closer or automatic door closer and a positive latching	K0029	K 029 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No residents were identified for the alleged deficient practice · Tinders Lock installed positive latching mechanisms and an astrical on the center of the door for a smoke barrier on 9/14/12. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	09/29/2012

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	mechanism to latch the door into the door frame. Based on interview at the time of observation, the Director of Maintenance acknowledged the east door in the set of two kitchen doors opening into the Main Dining Room did not self close and latch into the door frame. 3.1-19(b)		**practice does not recur** · Department Managers/designee will round daily to ensure a hazard free environment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Maintenance staff will conduct rounds If concerns arise the data collected will be submitted to the CQI committee for review. **Compliance date:** September 29, 2012	

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K0048 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects staff and visitors in the vicinity of the kitchen. Findings include: Based on review of "Fire Prevention" and "General Action Fire Plan" documentation with the Director of Maintenance during record review from 9:40 a.m. to 11:55 a.m. on 08/30/12, the facility's written fire safety plan did not address the use of ABC type fire extinguishers and the K-class fire	K0048	K 048 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No residents were identified for the alleged deficient practice · The Disaster Plan has been updated with the following: Appliance Fires in the Kitchen under the hoods—In the event of an appliance fire in the kitchen under the hood push the Ansel system button if the fire still needs extinguished then use the ABC fire extinguishers or the K class fire extinguishers **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Department Managers/designee will round daily to ensure a hazard free environment.	09/29/2012

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	extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Director of Maintenance acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Maintenance staff will conduct rounds. If concerns arise the data collected will be submitted to the CQI committee for review. **Compliance date:** September 29, 2012	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 combustible exterior canopies wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect 60 residents, staff and visitors using the Harrison Hall Main Entrance. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 12:10 p.m. to 2:55 p.m. on 08/30/12, the exterior canopy at the Harrison Hall Main Entrance extended twenty feet from the building, consisted partially of wood	K0056	K 056 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · No residents were identified for the alleged deficient practice Department Managers/designee will round daily to ensure a hazard free environment. **What measures will be put into**	09/29/2012

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	construction and was not provided with automatic sprinklers. Based on interview at the time of observation, the Director of Maintenance acknowledged the exterior canopy at the Harrison Hall Main Entrance was of combustible construction, extended more than four feet from the building and was not provided with automatic sprinklers. 3.1-19(b) 3.1-19(ff)		**place or what systemic changes you will make to ensure that the deficient practice does not recur** · A sprinkler system for the canopy at the Harrison Hall Main Entrance will be installed by September 29, 2012. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Maintenance staff will conduct rounds. If concerns arise the data collected will be submitted to the CQI committee for review. **Compliance date:** September 29, 2012	

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K0064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 2 of 2 portable K-class fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any staff or visitors in the vicinity of the kitchen. Findings include: Based on observations with the Director of Maintenance during a tour of the	K0064	K 064 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** No residents were identified for the alleged deficient practice · On 9/13/12 placards were placed in a conspicuously place near the two K-class portable fire extinguishers stating: In case of appliance fire, use this extinguisher after fixed suppression system has been actuated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Department managers/designee will round daily to ensure a hazard free environment **How the corrective action(s)**	09/29/2012

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	facility from 12:10 p.m. to 2:55 p.m. on 08/30/12, a placard was not conspicuously placed near the two K-class portable fire extinguishers which states the fire protection system shall be activated prior to using the K-class portable fire extinguisher. One K-class fire extinguisher was observed in the kitchen and the second K-class fire extinguisher was located in the service corridor outside the kitchen door. Based on interview at the time of the observations, the Director of Maintenance acknowledged a placard was not conspicuously placed near the two K-class portable fire extinguishers stating the fire protection system shall be activated prior to using the K-class portable fire extinguisher. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · Maintenance staff will conduct rounds. If concerns arise the data collected will be submitted to the CQI committee for review. **Compliance date:** September 29, 2012	